DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

May 31, 2023

Licensee
Harmony House Of Motley I
900 Eastwood Lane South
Motley, MN 56466

RE: Project Number(s) SL20572015

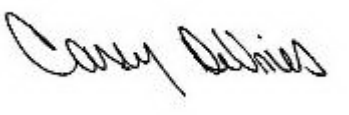
Dear Licensee:

On May 16, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the March 30, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter with your organization's Governing Body.

Please feel free to call me with any questions.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 651-281-9796

JMD

Electronically Delivered

April 12, 2023

Licensee
Harmony House of Motley I
900 Eastwood Lane South
Motley, MN 56466

RE: Project Number(s) SL20572015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on March 30, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

LICENSING ORDERS
The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this evaluation:

St - 0 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment - $3,000.00

The total amount you are assessed is $3,000.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and

submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

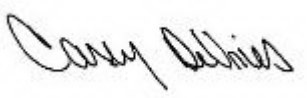
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
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St. Paul, MN 55101-3879
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 651-281-9796

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20572	A. BUILDING: _____ B. WING _____	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE OF MOTLEY I	900 EASTWOOD LANE SOUTH MOTLEY, MN 56466

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ****ATTENTION**** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL20572015-0 On March 27, 2023, through March 30, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were nine residents, all of whom received services under the provider's Assisted Living with Dementia license. An immediate correction order was identified on March 29, 2023, issued for SL20572015-0, tag identification 0820. On March 29, 2023, the immediacy of correction order 0820 was removed, however non-compliance remained at a scope and level of I.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request	0 460		

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0 460	Continued From page 1 assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide a means for residents to request assistance for health and safety needs as required for three of three (R1, R4, R5) residents. The licensee did not have a system in place for residents at the facility to request assistance for health and safety needs 24 hours a day, seven days a week. This had the potential to affect all nine (9) residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 460		

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0 460	Continued From page 2 The findings include: During the entrance conference on March 27, 2023, at 9:30 a.m., licensed assisted living director in residency (LALDR)-A stated the licensee did not have a system in place for residents to call for assistance for health or safety needs 24 hours a day, 7 days a week. LALDR-A stated two residents had been living in the basement until December 2022 and had been provided a pendant that could be used. The pendant would ring to a black box that was plugged into an outlet somewhere upstairs. The use of the pendant for R4 and R5 ended when the residents moved upstairs from the basement. Additionally, LALDR-A stated licensee's residents and staff should be in close enough proximity to hear the residents if assistance was needed R1 R1's diagnoses included dementia, congestive heart failure (CHF) and chronic anticoagulation. R1's Service Plan dated February 24, 2023, indicated R1 received assistance with activities, meals, bathing, bed mobility, dressing, grooming, medication administration, toileting, transfers, wound care, housekeeping and laundry. R1's Assessment dated March 21, 2023, indicated R1 was unable to ambulate due to a surgical hip repair performed on February 21, 2023, from a fall incident on February 20, 2023. R1 required two staff assist with toileting using a hoyer (mechanical lift device), assistance with incontinence monitoring and management, repositioning, ambulation, feeding and depended on staff to remind and encourage R1 to consume fluids due to R1's risk of dehydration.	0 460		

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0 460	Continued From page 3 R1's Individual Abuse Prevention Plan (IAPP) dated March 21, 2023, indicated R1 had an inability to care for self and R1 would receive 24-hour a day staff supervision and monitoring. Additionally, well-being checks would be conducted frequently. On March 27, 2023, at 11:55 a.m., the evaluator observed unlicensed personnel (ULP)-C and ULP-D assist R1 with preparations to attend lunch. ULP-C and ULP-D transferred R1 from his bed to a manual wheelchair with the use of a hoyer lift. On March 28, 2023, at approximately 9:50 a.m., the evaluator reviewed the fall history of R1 with clinical nurse supervisor (CNS)-B to include the review of a document titled Service Recap Summary dated March 2023. The documented services completed and signed off by staff did not include well-being/safety checks. CNS-B stated "the staff just know, it says to check on the resident every 3-4 hours in some of their tasks". The evaluator asked if CNS-B had a logbook or a record of documentation of the well-being checks being completed and CNS-B stated, "no, we don't have anything like that". R4 R4's diagnoses included dementia, bipolar disorder and chronic obstructive pulmonary disease (COPD). R4's Assessment dated March 20, 2023, indicated R4 required staff assistance with cues and reminders for dressing, grooming, toileting and eating. The assessment indicated R4 was independent with transfers and ambulation, however, would required stand-by assistance	0 460		

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0 460	Continued From page 4 from staff when R4 would experience unsteadiness. On March 28, 2023, at 8:35 a.m., the evaluator conducted an interview with R4. The evaluator asked R4 if she had a means to call for staff if she felt unsteady or needed assistance. R4 stated, "we don't have an alarm or anything, I just say I need you, we don't have an alarm, so I guess that's what we need to do. Ya, I would rather have an alarm then yell for help". R4's Assessment dated March 20, 2023, indicated R4 required staff assistance with cues and reminders for dressing, grooming, toileting and eating. The assessment indicated R4 was independent with transfers and ambulation, however, would required stand-by assistance from staff when R4 would experience unsteadiness. On March 28, 2023, at 8:35 a.m., the evaluator conducted an interview with R4. The evaluator asked R4 if she had a means to call for staff if she felt unsteady or needed assistance. R4 stated, "we don't have an alarm or anything, I just say I need you, we don't have an alarm, so I guess that's what we need to do. Ya, I would rather have an alarm then yell for help". R5 R5's diagnoses included bipolar disorder, Lewy Body dementia and schizo-personality disorder. R5's Assessment dated February 27, 2023, indicated R5 required staff assistance with cues and reminders for grooming, hygiene, toileting every two hours during the day and at times staff were to provide stand-by assistance when R5 experienced increased unsteadiness. R5 had a	0 460		

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0 460	Continued From page 5 walker available to use "that she may request to use at times". On March 28, 2023, at 8:40 a.m., the evaluator conducted an interview with R5. The evaluator asked R5 if she had a means to call for staff if she felt unsteady or needed assistance. R5 stated, "no, nothing like that. We all would use one at the same time, that's why we don't have one". On March 28, 2023, at 8:45 a.m., the evaluator asked ULP- E how residents call for assistance if needed. ULP-E stated, "most of them just holler. We are hoping with the new building it will work (a call system). In the past they have had doorbells to ding if they needed something. Some liked to use it, some just come and talk to us. Some their dementia progressed to the point it don't work. The rest just come find us". On March 28, 2023, at approximately 8:55 a.m., CNS- B stated R4 and R5 had call pendants when they resided in the basement area, however, call pendants were no longer provided to R4 and R5 after they moved upstairs. The evaluator asked CNS-B if R4 or R5 had been assessed for safety prior to removing the call pendants from them. CNS-B stated, "no, they were not assessed". Additionally, CNS-B stated safety checks "could be implemented if needed", however, no safety checks were assigned as a task for staff to complete, for any residents in the facility. The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) updated March 17, 2023, page 11, under the heading Security and Monitoring, indicated a "non-emergency call system; pendants	0 460		

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0 460	Continued From page 6 communicate to staff pagers", would be available to all residents. The licensee's policy titled Door Exits: Window Exits dated January 1, 2023, indicated licensee "would provide a nurse call pendant to our residents if one is requested. The resident is responsible for the pendant. If it is misplaced, damaged, or lost, the resident will be charged the current market price for a replacement cost". No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 460		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 480		

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0 480	Continued From page 7 or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated March 27, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of quality management activity activities, commensurate with the size of the business. This had the potential to affect all nine residents and staff.	0 580		

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0 580	Continued From page 8 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on March 27, 2023, at 9:30 a.m., licensed assisted living director in residency (LALDR)-A and clinical nurse supervisor (CNS)-B, indicated LALDR- A would have oversight of quality management activity. Neither the LALDR-A or CNS-B had knowledge of or were aware of the last quality management meeting held and no topics of discussion were known. LALDR-A stated he would have to find and review the book. The licensee's 2.30 Quality Management Plan policy, dated August 1, 2021, indicated the licensee will always have at least one documented quality improvement project in place, and retain record of such projects for at least two years. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
0 620 SS=D	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma (a) The assisted living facility must comply with	0 620		

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0 620	Continued From page 9 the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report an unwitnessed fall with a fracture to the Minnesota Adult Abuse Reporting Center (MAARC) for one of one discharged resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's diagnoses included dementia with behavioral disturbance, delirium, congestive heart failure (CHF) and macular degeneration. R3 was discharged on January 27, 2023. R3's record indicated R3 had a fall on December 15, 2022, that resulted in a fracture of the left hip requiring surgery. R3's Service Plan (waiver) - Addendum to Contract, dated December 9, 2022, indicated R3 received services including assistance with ambulation, bed mobility, transfers, toileting, bathing/showering, dressing, grooming,	0 620		

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	20572	A. BUILDING: _____ B. WING _____	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE OF MOTLEY I	900 EASTWOOD LANE SOUTH MOTLEY, MN 56466

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 620	Continued From page 10 medication administration, housekeeping and laundry. The Service Plan did not include well-being/safety checks. R3's Assessment dated December 8, 2022, indicated R3 required staff assistance with showering/bathing. "Staff are to assist individual with getting in and out of showering/bathing. Do not leave unattended while bathing/showering". Additionally, the assessment indicated R3 had impaired judgement and needed staff to observe for safety concerns and staff would monitor resident 24/7 to ensure safety and remove resident from potentially harmful/abusive situations. R3's progress notes dated December 15, 2022, written at 6:20 p.m. by unlicensed personnel (ULP), indicated the ULP heard R3 yell for help, the ULP found R3 lying on his left side. R3 was getting ready for a shower. The note further indicated the ULP called the on-call RN four times with no answer, so then called clinical nurse supervisor (CNS)-B. R3 indicated he hit his head, complained of being light-headed, and had a skin tear on left elbow about the size of a golf ball. R3 insisted he get up, so the ULP assisted R3 up. R3 then complained of left hip pain. The ULP assisted R3 to bed in a side lying position. The note indicated R3 almost cried in in pain. An update was entered into the same note, "Update, resident broke hip will have surgery tomorrow." R3's Resident Incident Report, completed on December 15, 2022, at 8:45 p.m., written by a ULP, and reviewed by CNS-B on December 16, 2022, at 8:21 a.m., indicated R3 was getting ready to take a shower, was "alone and unattended" and had hit his head on a clock in his room. R3 had yelled for help and was found on	0 620		

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0 620	Continued From page 11 the floor at 6:30 p.m. No alarm system being used at the time of the fall. The incident report indicated R3 was sent to the emergency room via ambulance at 7:30 p.m. R3's progress notes dated December 19, 2022, included a clinical update note written by CNS-B at 1:07 p.m., indicating R3 had returned to the facility following a surgical repair of the left hip and stitches for the skin tear on the left elbow, however, did not include investigative information completed by a licensed nurse or CNS-B of the fall incident with injury. On March 28, 2023, at 9:50 a.m., CNS-B stated a MAARC report had not been submitted because "the care plan was followed and there was no harm, would not expect a report to be filed with MAARC if the care plan is followed". Additionally, CNS-B stated, "we didn't suspect abuse, so we didn't think we needed to file a report". CNS-B stated the investigation of the fall was the information available in R3's progress notes. CNS-B stated staff had been unable to successfully reach the on-call nurse right away, and had called her [CNS-B] for direction, however, "I didn't ask or answer any questions. I just directed them to call the on-call again, and if they couldn't reach the on-call, to call me back." CNS-B confirmed the documentation by the ULP, including that staff had gotten R3 off the floor prior to speaking with a registered nurse, and added, "[R3] was adamant he wanted and needed to get off the floor, so to keep him comfortable, staff got him off the floor." The licensee's Report of Maltreatment of a Vulnerable Adult policy, revised August 1, 2021, indicated consistent with the Minnesota Vulnerable Adults Act and Assisted Living	0 620		

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0 620	Continued From page 12 licensure regulations, [licensee] sites prohibit the maltreatment of resident. To support this prohibition, [licensee] educates residents, family members, and team members (mandated reporters) about how to report suspected maltreatment internally and to MAARC. Team members who have knowledge that a resident has sustained a physical injury which is not reasonably explained will take immediate action to protect, or keep safe the resident affected, call for emergency assistance if needed, contact the CNS if medical attention is needed, contact the Assisted Living Director and the Assisted Living Director or CNS will determine how to best protect other residents from similar maltreatment in the immediate future. The policy provided did not address the investigative process by licensee or documentation of the investigative process. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity	0 780		

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0 780	Continued From page 13 of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide audible smoke alarms in all sleeping rooms. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: On a facility tour on March 29, 2023, at approximately 11:30 a.m. with licensed assisted living director in residency (LALDR)-A, maintenance (M)-H and director of operations (DO)-G, it was observed that smoke detectors were installed in all resident rooms throughout the	0 780		

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0 780	Continued From page 14 facility but did not provide audible notification within the resident room. Smoke alarms are required to provide audible notification within all resident sleeping rooms. On the tour LALDR-A, M-H and DO-G verbally verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 800		

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0 800	Continued From page 15 or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on March 29, 2023, at approximately 11:30 a.m. with licensed assisted living director in residency (LALDR)-A, maintenance (M)-H and director of operations (DO)-G, a fuel gas valve was observed with an open-ended pipe on the downstream side of the valve in the basement laundry room. This open-ended pipe with no cap or plug would dispense natural gas into the facility in the event of accidental opening of the valve. On the same facility tour, a heat detector in the common bathroom on the south end of the house was observed hanging from its wires outside the electrical box. Dead bolt locks were observed on the magnetically locked exterior exit doors. The magnetic lock with additional dead bolt lock requires two operations to release the doors to open. Exterior exit doors are required to release to open in one operation. These deficient conditions were visually verified by LALDR-A, M-H and DO-G accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and	0 810		

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0 810	Continued From page 16 maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to maintain the facility's fire safety and evacuation plan with required elements. This had the potential to directly affect all residents, staff, and visitors.	0 810		

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0 810	Continued From page 17 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). A record review and interview were conducted March 29, 2023, at approximately 1:30 p.m. of documents provided by licensed assisted living director in residency (LALDR)-A and director of operations (DO)-G on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Findings include: Record review of the available documentation indicated that the licensee did not maintain the fire safety and evacuation plan for the facility as follows: Record review of available documentation indicated the fire safety and evacuation floor plan did not include location, and numbers of resident rooms and detailed evacuation routes. Record review of the available documentation indicated that the fire safety and evacuation plan did not include fire protection procedures for residents in the event of a fire or similar emergency. Record review of the available documentation indicated that the fire safety and evacuation plan did not include procedures for employees regarding resident movement, evacuation, or	0 810		

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0 810	Continued From page 18 relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. Record review of the available documentation indicated that employees did not receive training on the facility fire safety and evacuation plan upon initial hire and twice per year thereafter. Record review of the available documentation indicated that the licensee did not provide training at least once per year to residents who are capable of self-evacuation on the proper actions to be taken in the event of a fire regarding movement, evacuation, and relocation. Record review of the available documentation did not indicate that evacuation drills had been conducted twice per year per shift and at least once every other month as required. All deficiencies were verified by LALDR-A and DO-G A during the interview at approximately 2:30 p.m. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must	0 820		

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0 820	Continued From page 19 be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect all residents and staff. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on March 29, 2023, at approximately 12:00 p.m. with licensed assisted living director in residency (LALDR)-A, maintenance (M)-H and director of operations (DO)-G, it was observed that emergency escape and rescue openings were not provided in resident sleeping rooms #4 and #5. Emergency escape and rescue openings are required in sleeping rooms of non-sprinklered facilities. This deficient condition was visually verified by LALDR-A, M-H and DO-G accompanying on the tour.	0 820	Hello Tim, Please see our responses to the 4 questions posed here: 1. One of the two residents is being moved over to the currently vacant room which has an egress window. The second of the two residents has approved moving temporarily into another room with egress window with 2 of her housemates. 2. Other residents affected by this include the housemates who will share the room and they both have been asked for their opinion and approval and are in agreement. In the future, all rooms will be private, as the building is currently under expansion/construction with an estimated completion date of 4/12/2023. Once construction is complete, this will be a non-issue. 3. All other bedrooms have egress windows, as did these 2 bedrooms except currently due to expansion/construction. Once expansion is complete, the entire facility will have a sprinkler system. 4. Once plan is approved, the plan can be completed within 2-3 hours. Shani Kedrowski	

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0 820	Continued From page 20 TIME PERIOD FOR CORRECTION: Immediate. On March 29, 2023, the immediacy of correction order 0820 was removed, however non-compliance remained at a widespread scope and level three of I.	0 820	Director of Operations Horizon Health, Inc. On March 29, 2023, the immediacy of correction order 0820 was removed, however non-compliance remained at a scope and level of I.	
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the	0 900		

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0 900	Continued From page 21 facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute a written contract, with the required content for one of one unlicensed personnel (ULP)-D) residing in the lower level of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On March 27, 2023, at approximately 10:30 a.m., licensed assisted living director in residency (LALDR)-A stated licensee did employ temporary contract staff and the temporary staff resided in a room in the lower unit of the facility. ULP-D was hired on August 8, 2022, to provide direct care for licensee's residents. On March 27, 2023, at approximately 11:55 a.m., ULP-D stated he had started employment with licensee "about August of last year" and resided in the lower level of the facility. On March 28, 2023, at 12:20 p.m., LALDR-A stated ULP-D had resided in a room in the lower level of the facility since being hired in August	0 900		

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0 900	Continued From page 22 2022 and was providing direct care services to the licensee's residents. On March 28, 2023, at approximately 2:20 p.m., the evaluator reviewed a document titled PowerScheduler Printout dated March 26, 2023 through April 8, 2023, which indicated ULP-D was scheduled shifts within the facility weekly. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 900		
01170 SS=E	144G.56 Subd. 3 Notice required (a) A facility must provide at least 30 calendar days' advance written notice to the resident and the resident's legal and designated representative of a facility-initiated transfer. The notice must include: (1) the effective date of the proposed transfer; (2) the proposed transfer location; (3) a statement that the resident may refuse the proposed transfer, and may discuss any consequences of a refusal with staff of the facility; (4) the name and contact information of a person employed by the facility with whom the resident may discuss the notice of transfer; and (5) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (b) Notwithstanding paragraph (a), a facility may conduct a facility-initiated transfer of a resident with less than 30 days' written notice if the transfer is necessary due to: (1) conditions that render the resident's room or private living unit uninhabitable;	01170		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01170	Continued From page 23 (2) the resident's urgent medical needs; or (3) a risk to the health or safety of another resident of the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to provide a 30-day calendar day advance written notice to the resident and/or the resident's legal/designated representative, prior to initiating the transfer for two of two residents (R4, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On March 27, 2023, at approximately 10:00 a.m., during the entrance conference, licensed assisted living director (LALDR)-A stated the licensee had transitioned two residents from a shared room in the lower level of the facility to a shared room upstairs in the main memory care area (ground level) on December 8, 2022. R4 and R5 moved from the basement room to the main floor area during December 2022. The licensee was unable to provide any documentation regarding the move for R4 or R5. The facility lacked documentation showing a 30-day written notification was provided to	01170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20572	A. BUILDING: _____ B. WING _____	03/30/2023

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HARMONY HOUSE OF MOTLEY I	900 EASTWOOD LANE SOUTH MOTLEY, MN 56466

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01170	Continued From page 24	01170		

residents and the residents' legal and designated representative as required that contained the following:
- (a) facility must provide at least 30 calendar days advance written notice to the resident and the resident's legal and designated representative of a facility-initiated transfer;
- the effective date of the proposed transfer;
- the proposed transfer location;
- a statement that the resident may refuse the proposed transfer, and may discuss any consequences of a refusal with staff of the facility;
- the name and contact information of a person employed by the facility with whom the resident may discuss the notice of transfer; and
- contact information for OOLTC.

On March 28, 2023, at 1:39 p.m., director of operation (DO)-G stated "we wouldn't have any notices or anything for when the residents were moved, we wouldn't have been required to have done that. They moved within the facility and it was after the regulation changed in 2021, both buildings were under the same license number at that time". Additionally, DO-G stated we don't know how many actually were moved, some were discharged to other facilities and we aren't able to find much for the record". DO-G was referencing two separate time periods. One transitional move of residents during May 2021, prior to regulation change, when licensee transitioned an unknown number of residents from and around the facility and the December 8, 2022, move transition of R4 and R5.

The licensee's Transfer of Residents Within Site policy updated October 25, 2022, indicated for the purpose of the policy "transfer" meant a move of a resident within the site to a different room or other private living unit. The site would provide at

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01170	Continued From page 25 least 30 calendar days advance written notice to the resident and the resident's legal and designated representative of a site-initiated transfer. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01170		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by:	01440		

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01440	Continued From page 26 Based on observation, interview and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing nursing services for one of two unlicensed personnel (ULP)-D. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On March 27, 2023, at 11:55 a.m., the evaluator observed ULP-D assist R1 with preparations to attend lunch and transfer R1 with a Hoyer lift (mechanical transfer device with a sling) from R1's bed to a manual wheelchair. ULP-D had a start date of August 8, 2022. ULP-D's employee record lacked documentation the RN supervised ULP-D performing the delegated tasks within 30 days of hire. On March 27, 2023, at 2:44 p.m., clinical nurse supervisor (CNS)-B stated they were unable to locate a completed 30-day supervision of delegated tasks for ULP-D. Additionally, CNS-B stated, "it may have been missed". The licensee's Supervision of Personnel - Delegated Services policy dated August 1, 2021, indicated direct supervision of staff performing	01440		

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01440	Continued From page 27 delegated tasks must be provided within 30 calendar days after the date on which the individual begins working and first performs the delegated tasks for resident and thereafter as needed based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
03000 SS=D	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has	03000		

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03000	Continued From page 28 been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report an unwitnessed fall with a fracture to the Minnesota Adult Abuse Reporting Center (MAARC) for one of one discharged resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	03000		

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03000	Continued From page 29 The findings include: R3's diagnoses included dementia with behavioral disturbance, delirium, congestive heart failure (CHF) and macular degeneration. R3 was discharged on January 27, 2023. R3's record indicated R3 had a fall on December 15, 2022, that resulted in a fracture of the left hip requiring surgery. R3's Service Plan (waiver) - Addendum to Contract, dated December 9, 2022, indicated R3 received services including assistance with ambulation, bed mobility, transfers, toileting, bathing/showering, dressing, grooming, medication administration, housekeeping and laundry. The Service Plan did not include well-being/safety checks. R3's Assessment dated December 8, 2022, indicated R3 required staff assistance with showering/bathing. "Staff are to assist individual with getting in and out of showering/bathing. Do not leave unattended while bathing/showering". Additionally, the assessment indicated R3 had impaired judgement and needed staff to observe for safety concerns and staff would monitor resident 24/7 to ensure safety and remove resident from potentially harmful/abusive situations. R3's progress notes dated December 15, 2022, written at 6:20 p.m. by unlicensed personnel (ULP), indicated the ULP heard R3 yell for help, the ULP found R3 lying on his left side. R3 was getting ready for a shower. The note further indicated the ULP called the on-call RN four times with no answer, so then called clinical nurse	03000		

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03000	Continued From page 30 supervisor (CNS)-B. R3 indicated he hit his head, complained of being light-headed, and had a skin tear on left elbow about the size of a golf ball. R3 insisted he get up, so the ULP assisted R3 up. R3 then complained of left hip pain. The ULP assisted R3 to bed in a side lying position. The note indicated R3 almost cried in in pain. An update was entered into the same note, "Update, resident broke hip will have surgery tomorrow." R3's Resident Incident Report, completed on December 15, 2022, at 8:45 p.m., written by a ULP, and reviewed by CNS-B on December 16, 2022, at 8:21 a.m., indicated R3 was getting ready to take a shower, was "alone and unattended" and had hit his head on a clock in his room. R3 had yelled for help and was found on the floor at 6:30 p.m. No alarm system being used at the time of the fall. The incident report indicated R3 was sent to the emergency room via ambulance at 7:30 p.m. R3's progress notes dated December 19, 2022, included a clinical update note written by CNS-B at 1:07 p.m., indicating R3 had returned to the facility following a surgical repair of the left hip and stitches for the skin tear on the left elbow, however, did not include investigative information completed by a licensed nurse or CNS-B of the fall incident with injury. On March 28, 2023, at 9:50 a.m., CNS-B stated a MAARC report had not been submitted because "the care plan was followed and there was no harm, would not expect a report to be filed with MAARC if the care plan is followed". Additionally, CNS-B stated, "we didn't suspect abuse, so we didn't think we needed to file a report". CNS-B stated the investigation of the fall was the information available in R3's progress notes.	03000		

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03000	Continued From page 31 CNS-B stated staff had been unable to successfully reach the on-call nurse right away, and had called her [CNS-B] for direction, however, "I didn't ask or answer any questions. I just directed them to call the on-call again, and if they couldn't reach the on-call, to call me back." CNS-B confirmed the documentation by the ULP, including that staff had gotten R3 off the floor prior to speaking with a registered nurse, and added, "[R3] was adamant he wanted and needed to get off the floor, so to keep him comfortable, staff got him off the floor." The licensee's Report of Maltreatment of a Vulnerable Adult policy, revised August 1, 2021, indicated consistent with the Minnesota Vulnerable Adults Act and Assisted Living licensure regulations, [licensee] sites prohibit the maltreatment of resident. To support this prohibition, [licensee] educates residents, family members, and team members (mandated reporters) about how to report suspected maltreatment internally and to MAARC. Team members who have knowledge that a resident has sustained a physical injury which is not reasonably explained will take immediate action to protect, or keep safe the resident affected, call for emergency assistance if needed, contact the CNS if medical attention is needed, contact the Assisted Living Director and the Assisted Living Director or CNS will determine how to best protect other residents from similar maltreatment in the immediate future. The policy provided did not address the investigative process by licensee or documentation of the investigative process. No further information was provided.	03000		

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03000	Continued From page 32 TIME PERIOD FOR CORRECTION: Seven (7) days	03000		

Minnesota Department of Health
Food, Pools & Lodging Section
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *03/27/23*
Time: 11:00:00
Report: 6808231082

Food and Beverage Establishment Inspection Report

Location:
Harmony House Of Motley I
900 Eastwood Lane South
Motley, MN56466
Morrison County, 49

Establishment Info:
ID #: 0038564
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 2183526941
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

3-500D Microbial Control: disposition of food
3-501.18A ***** Priority 1 *****
MN Rule 4626.0405A Discard all TCS food prepared in the establishment or opened commercially packaged food when the time exceeds 7 days from the preparation or opening date or if the container or package is not marked.
DISCARD THE PUDDING DATED 3/19.
Comply By: 03/27/23

4-700 Sanitizing Equipment and Utensils
4-702.11 ***** Priority 1 *****
MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.
SINCE THE CURRENT DISHWASHER IS NOT WORKING AND THERE IS NO 3 COMPARTMENT SINK, THE NEW KITCHEN 3 COMPARTMENT SINK AND/OR DISHWASHER MUST BE USED FOR SANITIZING.
Comply By: 03/27/23

4-300 Equipment Numbers and Capacities
4-302.14 ***** Priority 2 *****
MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
PROVIDE A CHLORINE TEST KIT FOR THE CHLORINE SANITIZER CURRENTLY BEING USED.
Comply By: 03/28/23

6-300 Physical Facility Numbers and Capacities

6-301.11 ***** Priority 2 *****

MN Rule 4626.1440 Provide an adequate supply of hand soap at each handwashing sink or group of 2 adjacent handwashing sinks.

AT NEW KITCHEN HAND WASH SINKS

Comply Before Opening

6-300 Physical Facility Numbers and Capacities

6-301.12C ***** Priority 2 *****

MN Rule 4626.1445C Provide and maintain at each handwash sink in toilet rooms and other areas that are not used for food preparation or warewashing, a supply of individual disposable towels, a continuous towel system that supplies the user with a clean towel, or a heated hand drying device.

AT NEW KITCHEN HAND WASH SINKS

Comply Before Opening

4-900 Protecting Clean Items

4-903.12A

MN Rule 4626.0960A Discontinue storage of food, clean equipment, linens, utensils, or single-service and single-use articles in locker rooms; toilet rooms; garbage rooms; mechanical rooms; under unshielded sewer lines; under leaking water lines or sources of condensation or moisture; under open stairwells; or under other sources of contamination.

REPLACE CEILING TILES IN PANTRY AREA.

Comply By: 03/28/23

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

PROVIDE SIGNS AT NEW KITCHEN HAND WASH SINKS.

Comply By: 03/28/23

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	2	3	2

A PLAN REVIEW WAS SUBMITTED TO HRD AND APPROVED. THE NEW KITCHEN WAS INSPECTED AND APPEARS TO BE IN COMPLIANCE WITH THE FOOD CODE. PLUMBING PLANS WERE ALSO SUBMITTED.

Food and Beverage Establishment Inspection Report

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 6808231082 of 03/27/23.

Certified Food Protection Manager: Thomas Sandberg

Certification Number: _____ Expires: 01/13/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: Lee Ann Austin

Lee Ann Austin
Public Health Sanitarian
St. Cloud
320-223-7341
leeann.austin@state.mn.us